MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 18, 2001
10:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Updating Medicare payments
Nancy Ray, Jack Ashby

MS. RAY: This is a companion piece to Jack's analysis that we just went over. When making update recommendations, the first issue policymakers should consider then is evidence about whether the base payment rate is appropriate. As suggested in Jack's presentation, we are proposing to carry over the conclusions drawn about the appropriateness of the base payment into the update analysis. That is, MedPAC's update recommendation would include an adjustment to the base payment rate if the Commission finds that the base payment rate is either too high or too low.

The second issue that the Commission needs to consider when making an update recommendation is the effect of factors on providers' costs in the next payment year. Specifically at issue is how the Commission should evaluate factors that change providers' cost in the next payment year. My mailing materials under Tab I propose modifying this approach that has been used by MedPAC in previous years.

Just a brief review of what the Commission and other groups have typically used in examining factors that may change providers' cost in the next payment year. The first one being the inflation for input prices. This factor estimates how much costs are expected to rise or go down in the next payment year, holding constant the quality or mix of inputs providers use to furnish care and the types of patients they treat. Typically for facility-based care like hospitals and nursing facilities and dialysis we use the marketbasket concept. In contrast, for physician care, that is partly based on the MEI.

The allowance for scientific and technological advances, the S&TA, is intended to raise base payment rates to accommodate the expected effects of new technologies in the next payment year that improve quality of care but also increase costs. Improvements in productivity reflect the expectation that in the aggregate providers should be able to reduce the quantity of inputs required to produce a unit of service while maintaining service quality.

Finally, a recent addition to the MedPAC framework would be one-time factors that adjust payments for one-time factors that affect the cost of providing services that are systematic and substantial and that will improve care for beneficiaries. Examples of such one-time factors include a one-time factor for new regulatory requirements like HIPAA, and outside effects like Y2K.

So staff are proposing that the Commission focus its analysis of changes in the cost in the next payment year around the input price measure. We propose doing so because the estimate of price inflation is probably the most important factor influencing providers' cost in the next payment year. In addition, these measures can, for most service areas, be readily projected from eyar to year.

We are explicitly proposing not to annually project the

effect for the other factors that we have in the past looked at on an annual basis, including the S&TA, that affect providers' costs. These factors generally account for a smaller impact on providers' costs in the next payment year and there are some methodological issues about whether they can be reliably projected on an annual basis.

We are proposing that the Commission would consider examining the effect of these other factors like the S&TA only when sufficient evidence shows that their collective effect might be significantly affecting providers' costs.

Adopting this approach would change the relative importance of factors in MedPAC's update framework, increasing reliance on measures assessing the appropriateness of the base payment and measures of changes in input prices in the next payment year, and decreasing reliance on measures estimating changes in providers' costs ending next payment year due to scientific and technological advances, and one-time factors, and productivity improvements.

Staff look forward to the Commission discussion on this proposal. I just wanted to point out that adopting this approach does put a lot of pressure in measuring the input price inflation as accurately as possible, and using measures that are consistent, to the extent possible, across the different service settings for which we are making recommendations. In your mailing materials we raise some of the issues, a few issues that staff need to look at in greater detail when trying to measure input price inflation.

For example, one issue that we are going to be addressing is whether the wage component of the marketbasket for inpatient hospitals, should that solely be based on wage increases experienced by hospitals? Right now this is not the case. The factor in the marketbasket measuring changes in labor cost for inpatient services is weighted roughly one-third for hospital wage increases and two-thirds based on the general economy.

There are also issues with regards to the MEI, including a productivity component. We will be coming back to you with this and other issues to consider for the December meeting. For now however, staff would like the Commission's input on whether we're on the right track with our proposal.

DR. ROSS: I wanted to be clear on something that's in one of the overheads here where we talk about considering other factors only if they will affect providers' costs in a significant way. That is not to be taken as we are ignoring those factors. Instead it should be viewed as being two things. One is, for many of them, which conveniently at the end of the day turn out to be offsetting, it means we're going to devote fewer of our resources, analytic and discussion time, to dealing with things that we eventually conclude exactly offset each other and net out to zero.

But second, to the extent there are real issues there, they get swept up in the review of payment adequacy that Jack talked about in round one of all this. So to the extent that there is, for example, a significant change that perhaps gets mixed, it gets picked up in the next round.

But I want to be clear, these are not being ignored. This is just a way of treating them, if you will, on net rather than with each individual line item and spending a lot of time digging through the pieces.

MR. DEBUSK: How will we handle this nursing shortage and hospital personnel shortage that we're going to go into here -- that we're already into -- going forward from the standpoint of cost?

DR. ROSS: To the extent it's reflected in rising wages, that feeds directly through in the marketbasket.

MR. HACKBARTH: There are two pieces to that. One is the one just raised about, maybe we should use a different marketbasket measure for wages, from one that's 100 percent hospital-based as opposed to 30 now. But then the second piece -- and one of the features of this framework that I like is the one that Murray highlighted. Again, if we make mistakes, the re-basing step the following year includes a corrective piece, so that we make sure that they don't get magnified over time.

DR. REISCHAUER: Jack, would the assumption be that we would look at the adequacy of the base payment every year?

MR. ASHBY: We had some considerable of that. I think that would be the model, if you will. But as a practical matter, I suspect what will really happen is that this will be a major issue once, and then we'll get to where we think we are, and then it will be just sort of adjusting from that. Kind of akin to, you do a full audit once and then you do some desk audits for a while. I think that's, as a practical matter, how it will carry out.

MR. HACKBARTH: On the specific issue that Pete has raised, the issue of whether we change the wage calculation, when will that come back? Will that be at the next meeting?

MR. ASHBY: Either at the November or December meeting; just a matter of how quickly we can get ready. But we do tend to think that it's an important issue, as Nancy said, so we'll get on it.

DR. NELSON: Since the proposal is to anchor the update around the estimate of price inflation for each provider group, how close have the estimates been to the actuals over the last decade or so? Have the estimates been -- you say the estimates are the only reliable source. We have experience. All you have to do is take your estimate and find out how close the estimators were. What has been the experience with comparison with the actuals?

MR. ASHBY: I can speak to that for the hospital marketbasket. We had a rather incredible run where HCFA overshot the mark seven years in a row. I don't mean to be critical in saying that because forecasting is not a precise science. But this last year it most definitely --

DR. ROWE: Which means they didn't overshoot it by the same amount each year.

MR. ASHBY: No. And they were all little increments, but it added to about a three percentage point error over seven years. But this last year very definitely went the other way. This was emerging evidence of labor shortages that Pete talks about, and I

don't think that the forecasters really quite caught what was going on as quickly as it did, so we were off in the other direction by 0.7 point last year.

DR. NELSON: Can I get a little more clarification? Give that to me in some sort of multiplier off the estimate. If the estimate was 3 percent and it came in 2.5 percent, that's missing it by 20 percent. How close, generally, did they come?

MR. ASHBY: I don't know that I ever put it in those terms. I guess we just count percentage points off, so I'm not sure that I know the answer to that actually.

DR. ROSS: But you have a marketbasket that averaged somewhere around 3 percent over the decade, between 3 and 4 percent?

MR. ASHBY: Yes. I guess that would be right.

DR. ROSS: So it's 3 percent cumulative on something on the order of a 30 to 45 point change?

MR. ASHBY: Of 30 percentage points of change, right. I guess that would be right.

DR. ROSS: But again, Alan, one of the issues with the approach proposed here is that in the past where the Commission has always had a little line item for correcting for marketbasket forecast error, in fact that now gets thrown in with all the possible errors one might make, including failure of Congress to enact recommendations. When you come back the year following you say, let's look at payment adequacy and ask whether the base is appropriate or not. So it still gets accounted for. It gets accounted for in a different place.

MR. HACKBARTH: Any further comments or questions?

DR. NEWHOUSE: If we decide to go to 100 percent hospital weighting on the wage index, or that's coming back?

MR. HACKBARTH: It's coming back as I understand it.

MS. RAY: That's coming back.

MR. ASHBY: Yes, we'll come back to that.

MR. SMITH: And we'll look at options other than 30 and 100.

MR. ASHBY: We can. The first question to ask is the philosophical one, is there any reason to be somewhere else than 100? That's what we need to focus on and then go from there.

DR. REISCHAUER: I wonder from a practical, political standpoint whether we can get away with not discussing the things that we don't know much about when people are concerned about. Meaning all the various little technological or markets, things that we spend a lot of time on and then we say, well, that's about the same as productivity; we'll put in zero. My guess is we're going to have to do the same thing, just to show we're cognizant of these issues that people care about.

DR. ROSS: Yes. Again, that's why I want to say, we're not ignoring these. I guess we're, to a certain extent, proposing to admit our ignorance and our inability to measure them to the nearest one-tenth of a percentage point.

DR. REISCHAUER: I'm not disagreeing with where we are. But in a sense what you're saying is --

DR. ROSS: You're saying I shouldn't hope to get away with --

DR. REISCHAUER: -- under Tab I, so you don't even have K --

that discussion next year.

DR. ROSS: You're bursting my bubble is what you're doing. Don't hope for short sessions on the update.

DR. NEWHOUSE: Bob, the other issue is how far do you go down that path? ProPAC used to contract every year for a study of scientific and technological advance, which MedPAC did once, twice? Anyway, you can pursue this in greater or lesser detail.

MR. SMITH: Let me just test my reading on that point, Bob. It seems to me with what's being proposed here, and seems right to me, remembering the complicated session we had before we netted productivity and S&TA last spring, is that what the staff seems to be saying in lay terms is, we need a reasonably high threshold before we have the conversation. We need a higher threshold than we've had in the past. You need to make a case that something is so important that it ought to be singled out. Other than that, our crude netting formula, that ought to be the presumption.

We ought to remember that the next time we're leaned on to take account of some particular thing. We ought to insist on a pretty high threshold. I think the staff is right.

MR. HACKBARTH: Okay, I think we've covered what we need to cover today, and we are now -- I'm not saying for the day. On this particular topic. But I was just going to marvel at the fact that we're going to get ahead of schedule here. The next item for us is payment for physician services; Kevin.